

# NEW JERSEY SHBP EMPLOYEE DENTAL PLANS APPLICATION

Division of Pension and Benefits, P.O. Box 299, Trenton, NJ 08625-0299

## 1. EMPLOYEE INFORMATION-This section must be filled out completely. Please print or type.

Social Security Number

-   -

Last Name

Title (Jr., Sr., etc.)

First Name

MI

Street Address (Include Apartment #)

City

State

ZIP Code + 4

-

Date of Birth (mm/dd/yy)

Gender (M/F)

Status:

☐ -Single ☐ -Married ☐ -Domestic Partnership ☐ -Divorced ☐ -Widowed

Are you transferring from another SHBP participating employer? ☐ Yes ☐ No

(Area Code)

Home Telephone Number

-

If yes, name of employer:

## 2. DENTAL COVERAGE

**2a. EMPLOYEE SELECTION** (You must remain enrolled in the Dental Plan for a minimum of 12 months)

☐ I wish to be covered under the Dental Expense Plan.

☐ I wish to be covered under a Dental Plan Organization (DPO).

Name of DPO

DPO#

Name of Dentist or ID#

☐ I am changing dental plans only:

From

To

☐ I elect to waive dental coverage in any dental plan (see instructions).

## 2b. LEVEL OF COVERAGE

☐ Single

☐ Member and Spouse

☐ Parent and Child(ren)

☐ Family

☐ Member and Domestic Partner (see instructions)

## DIVISION USE ONLY

Effective Dates:

Event Reason:

D

## EMPLOYER CERTIFICATION

See instructions on reverse

Employer

Name:

Payroll #

(State Biweekly)

Union Code

(Rx) Only

Location # (State Monthly or Local/Educational)

10/12 month employee  
(Enter "10" or "12")

## MEMBER ACTION

☐ New Enrollment

☐ Transfer

Date Employment Began    /    /

(mm/dd/yy)

☐ Return from

Leave of Absence    /    /

Signature of Certifying Officer

Telephone #

Date Mailed

## 3. DEPENDENT INFORMATION - List only eligible dependents (see instructions on reverse).

☐ Spouse ☐ Domestic Partner

Last Name

First Name

MI

Date of Birth (mm/dd/yy)

(M/F)

Gender

Social Security Number

Name of  
Dependent's Dentist or ID#

Natural (C)  
Adopted (A)  
Foster (F)  
Step (S)  
Legal Ward (L)  
See Instructions

-   -

-

Children

-   -

-

-   -

-

-   -

-

-   -

-

## 4. TYPE OF ACTIVITY

(complete only if requesting changes to existing coverage)

### 4a. ADDITION OF DEPENDENT

☐ Marriage -

Date of Event (mm/dd/yy)

(Copy of Marriage Certificate required)

Former Name

☐ Domestic Partner - Date of Event (mm/dd/yy)

(Copy of Certificate of Domestic Partnership required)

☐ Birth of Child

☐ Adoption/Guardianship - proof required

Date of Event (mm/dd/yy)

### 4b. DELETION OF SPOUSE OR DOMESTIC

#### PARTNER

☐ Separation ☐ Divorce ☐ Death

☐ Termination of Domestic Partnership

Date of Event (mm/dd/yy)

### 4c. DELETION OF CHILD

☐ Deletion of Child -

Date of Event (mm/dd/yy)

Child's Name

Child's SSN

Give Reason

### 4d. OTHER CHANGES

☐ Change in last name only

(Attach copy of supporting documentation)

(List former name)

☐ Change in Soc. Sec. #

(Attach copy of Social Security card)

(List former Soc. Sec. #)

☐ Change in Birth Date

(Attach copy of birth certificate) (List name and correct date)

☐ Other - give reason (i.e., address change, depend-

ent returns from military service)

**5. EMPLOYEE CERTIFICATION** - I certify that all the information supplied on this form is true to the best of my knowledge and that it is verifiable. I understand that if I waive my right to coverage at this time, enrollment is not permissible until the next scheduled open enrollment or if other coverage is lost and proof of loss is provided (HIPAA). I understand that I must remain enrolled in the Dental Plan for a minimum of 12 months and that there is no guarantee of continuous participation by dental service providers, either dentists or facilities in the DPO plans. If either my dentist or dental center terminates participation in my selected plan, I must select another dentist or dental center participating in that plan to receive the "in-network" benefit. I authorize any hospital, physician, dentist, or dental care provider to furnish my dental plan or its assignee with such dental information about myself or my covered dependents as the assignee may require.

**Misrepresentation:** Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

Employee Signature

Date Completed

## INSTRUCTIONS FOR THE NJ SHBP GROUP DENTAL PROGRAM APPLICATION

- **To change your dentist** with your DPO, contact your dental plan directly. **DO NOT COMPLETE THIS FORM JUST TO CHANGE YOUR DENTIST.**
- **To enroll** for the first time complete all sections of the application with the exception of section 6.
- **To change dental plans only** complete sections: 1, 2a and 2b (if enrolling in a DPO be sure to list the name of your dentist or his/her identification number), 3 (listing all eligible dependents), and 5.
- **To change coverage level** (adding/deleting dependents) complete sections: 1, 2a and 2b, 3 (listing all eligible dependents), 4 (listing why you are changing coverage level), and 5.
- **To add a dependent** complete sections: 1, 2a and 2b, 3 (listing all eligible dependents), 4a, and 5.
- **To terminate/decline coverage** complete sections: 1, 2a, and 5. If you are declining enrollment for yourself or any or all of your eligible dependents because of other group dental insurance coverage, you may in the future be able to enroll yourself and/or your eligible dependents in a SHBP dental plan, provided that you request enrollment within 60 days after your other group health coverage ends.

### SECTION 1 - EMPLOYEE INFORMATION

This section must be completed in its entirety each time an application is submitted. The employee enrolling or enrolled in the plan completes this section.

### SECTION 2 - DENTAL COVERAGE

- 2a.** Check only one box indicating the dental plan you wish to be enrolled in. If you do not want dental coverage or wish to cancel coverage, check the box to waive coverage.
- 2b.** If you are electing coverage, check the level of coverage desired. (if enrolling a domestic partner, see "Domestic Partner" below).

**NOTE: Once enrolled, you and your eligible dependents must remain in the plan you elect for a minimum of 12 months before you can switch plans or drop coverage.**

**DOMESTIC PARTNER: Domestic Partner coverage is available to State employees and to Local/Educational employees whose employer has adopted a resolution to participate in Chapter 246, P.L. 2003, The Domestic Partnership Act.** A domestic partner is defined for eligibility in the SHBP, by Chapter 246, P.L. 2003, as a person of the same sex with whom you have entered into a domestic partnership and received a *Certificate of Domestic Partnership* from the State of New Jersey (or a valid certification from another jurisdiction that recognizes same-sex domestic partners, civil unions, or similar same-sex relationships). The cost of domestic partner coverage may be subject to federal tax (see your employer or Fact Sheet #71, *Benefits Under the Domestic Partnership Act*, for more information). If covering a domestic partner as a dependent, you must attach a photocopy of your *Certificate of Domestic Partnership* to this application.

**NOTE: Once you decline or cancel Medical, Prescription Drug, or Dental coverage, enrollment is not permissible until the next open enrollment period or if other coverage is lost and proof of loss is provided (HIPAA).**

### SECTION 3 - DEPENDENT INFORMATION (No employee or dependent can be covered under more than one State Dental Plan.)

**Only eligible dependents may be listed.** Completion of this section is essential for proper enrollment. Be sure dependents listed agree with the level of coverage selected in sections 2b. List the name, date of birth, gender, and Social Security number of the family members you wish to be covered under the plan. An eligible spouse is an individual to whom you are legally married. An eligible domestic partner is an individual of the same-sex with whom you have entered into a domestic partnership (see note in instructions for Section 2, above). If you have listed a child that is an adopted child, foster child, stepchild, legal ward, or has a different last name than the employee, proof of dependency is required (contact your payroll/personnel representative for an *SHBP Affidavit of Dependency* form). If you have more than 4 eligible dependent children, attach a separate application and complete Sections 1, 3, and 5. For all dependents, include the dentist's name or identification number. All dependents must have this information listed. Refer to the DPO directory for this information or call the dental plan directly.

**NOTE: If you are deleting dependents, do not list them in this section. Refer to section 4b and 4c.**

### SECTION 4 - TYPE OF ACTIVITY

- 4a.** If you are adding a dependent, check the appropriate box and indicate the event date.
- 4b.** If you are deleting a dependent spouse or domestic partner, check reason and indicate the event date.
- 4c.** If you are deleting a dependent child, indicate the event date, list the child's Social Security number, and give reason.
- 4d.** For other changes, check the appropriate box, give requested information, and attach a copy of supporting documentation if applicable.

### SECTION 5 - EMPLOYEE CERTIFICATION

You must read the Employee Certification statement, **sign it, and date the application.**

**Misrepresentation:** Any person that knowingly provides false or misleading information is subject to criminal and civil penalties.

### EMPLOYER CERTIFICATION

**Must be completed by your employer** before submitting the application to the SHBP. By signing this application the employer certifies that:

- 1) The employee is eligible;
- 2) The application is legible and completed in its entirety;
- 3) The employee's selected plans and coverage levels are appropriate;
- 4) The Employer Certification section is completed in its entirety; and
- 5) The information presented is true to the best of their knowledge.